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Editorial

Dr Jackie Watts, Editor in Chief, MSo

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In this issue of MSo, our last for 2013, we have a variety of content that we hope readers will find engaging. As is customary for the October issue, we include a focus on the annual BSA MedSoc conference held this year in York. The conference attracted a record number of delegates and we are pleased to include commentaries containing reflections on the event from five of the sponsored delegates. Spotlight on the 2013 conference will extend to our next issue in February 2014 when we expect to publish papers from the two plenary speakers, Professors Catherine Pope and Sarah Cunningham-Burley.

This issue opens with two peer-reviewed articles each looking at different aspects of child health. David Ugal's article discusses maternal and child mortality in urban centres in Nigeria. The article reports that, despite government policy initiatives to address poor reproductive health indicators, there has been only minimal improvement in women's educational status and no improvement in other areas including vaccination against childhood killer diseases. The article by Emma Doyle from the University of Edinburgh has as its theme parents seeking advice about children's health in a dedicated online forum. The role of online peer support that focuses on experiential knowledge is highlighted to draw out the strength of 'lay' referral networks that serve as a significant source of health advice to parents.

The article we have selected from the MSN/MSo archive discusses gender, health and ageing and is authored by Professor Sara Arber from the University of Surrey. This was a plenary paper presented to the 1994 BSA MedSoc conference and Sara has contributed some thoughts on the ways in which some of the issues raised in the paper still resonate whilst others have become outdated. The final Book Review section has three reviews on recently published texts on the topics of class and lifestyle, causes of health and disease and the issue of gender and mental health. Book reviews are a good way to start being published and we would like to encourage postgraduate students and other early career researchers to consider submitting a short review for Medical Sociology online.

Unlike recent issues of MSo, we do not have any PhD abstracts to include so please send us these 'good news' pieces that help to update the medical sociology community on recent research in our field.

Coinciding with the publication of this issue, we have two exciting developments to report about our website (www.medicalsociologyonline.org). Firstly, our project to make available a complete Archive of all issues of Medical Sociology News (MSN) and Medical Sociology online (MSo) – dating back to the autumn of 1973 – is making tremendous progress. The Archive on the website now goes back as far as December 1985 (MSN Issue 11.1) and the remaining content will be added in the coming months, including the first ever issue of MSN.

Secondly, in what we believe is a first, many of the Poster Presentations from the York BSA MedSoc conference can now be viewed online. We see this as an innovative way of helping early career researchers gain the maximum exposure for their work and we look forward to publishing posters from other relevant conferences in the future.

Finally, we would like to extend our thanks to contributors and colleagues at the BSA and in the wider medical sociology community for their continued support.

Government Health Policies, Maternal Educational Status and the State of Maternal/Child Health in Urban Nigeria: Assessment from the NDHS 1999-2008

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ABSTRACT

Despite government policies on reproductive health, maternal and child mortality in Nigeria remains high. This study was undertaken to examine the state of maternal and child health in urban Nigeria. Data used for the study was drawn from the last three National Demographic Health Survey (NDHS). Objectives include antenatal attendance, children vaccination, and educational status. There was little improvement in the educational status of women, all other variables showed, very marginal or no improvement. The majority of the women had antenatal care by Traditional Birth Attendant's (TBAs). Almost 40 percent of the women delivered outside any health facility and about the same figure were assisted by unskilled professionals. Vaccination against childhood killer diseases showed no improvement within the period preceding the latest survey. Up to 2008, only 37.5 percent of children received all vaccinations.

Key Words: Health policies, Maternal Education, Maternal and Child health, Nigeria

BACKGROUND OF THE STUDY

Each year, millions of women, newborns and children worldwide die from preventable causes. While interventions that could save their lives are widely known, they are often not assessable to those most in need (Sines, et al, 2006, & Knippenberg, et al 2005). More than 60 million women deliver at home without skilled care. WHO (2005) maintained that around 530,000 women die from pregnancy related complications with 68,000 of these deaths resulting from unsafe abortion. Furthermore, the World Health Organization (2005) reported that about 4 million babies die within the first month of life (the new born period and more than 3 million die as stillbirths and over 10 million children under the age of 5 also die). Black et al (2003) stated that nearly 99 percent of maternal, newborn and child deaths occur in low and middle income countries.

Nigeria Urban Reproductive Health Initiative NURHI (2009) maintained that Nigeria is Sub-Saharan Africa's most populous nation with 149 million citizens, nearly half of whom are under the age of 15. Despite being an oil rich country, Nigeria has some of the worst health indicators in the world, as evidenced by its health system performance ranking 187 among 191 member states (NURHI, 2009).

Unlike many Sub-Saharan African countries, Nigeria has a highly urbanized population. In 2003 it was estimated that about 47% of Nigerians lived in an urban environment. At present, Nigeria has at least ten cities with over a million residents. Lagos's population is estimated at well over 9 million and the United Nations (UN) projects that by 2015 it will be included in the world's list of "megacities" with over 10 million people. The challenges on

Nigeria's urban health infrastructure will only increase. By 2035, over half of Nigeria's poor citizens are projected to be living in urban areas. Most will live in slums with little access to basic facilities (NURHI 2009).

Statement of Problem

Despite various National and International initiatives to improve maternal and child health, more than half a million women and children from developing countries still die each year as a result of complications related to pregnancy and child birth (WHO, 2005, NPC, 1999).

Complications of pregnancy and childbirth are the leading causes of death and disability among women of reproductive age in less developed areas. In addition, at least 20 percent of the burden of disease among children below five years is attributable to conditions directly associated with poor maternal health, nutrition, and the quality of obstetric and newborn care, yet, most of these deaths and sufferings are preventable (NPC, 2004).

This situation is still prevalent despite several interventions aimed to improve maternal and child health. The safe motherhood initiative was introduced to suggest strategic interventions to reduce maternal and child morbidity and mortality. The Integrated Maternal, Newborn and Child Health (IMNCH) Strategy introduced in 2007 to fast track high-impact intervention packages that include nutritional supplement, immunization, insecticide-treated mosquito nets and prevention of mother- child transmission of HIV has not created any change in the morbidity and mortality rates of mothers and their children.

The United Nations (2007), maintained that its' Millennium Development Goals 4 and 5 -to reduce child and maternal mortality by 75 percent and to achieve universal access to reproductive health by 2015 has made the least progress of all MDGs. At global levels, maternal and child mortality decreased by less than 1 percent per year between 1990 and 2005-far below the 5.5 percent annual improvement needed to reach the target. At this rate, MDGs 4 and 5 will not be met in Asia until 2076 and many years later in Africa.

In the face of all these situations, the reproductive health policies of the Nigerian government has been reviewed severally beginning from 1988 to the latest (IMNCH) in 2007, yet, very little is known about the actual effect of these policies on the state of maternal and child health generally and in urban areas of the country particularly.

There are 11,000 maternal deaths for every 100,000 live births in Nigeria. Every year 59,000 Nigerian women die during pregnancy and child birth-the second in the world (after India). The majority of these deaths, as in the rest of the world, are preventable. While the casual factors can be multiple and complex, governments must be aware about the ongoing loss of women and children's lives (Shiffman, 2007). The Nigerian government has repeatedly identified maternal and child mortality and morbidity as a pressing problem and developed laws and policies in response, however, these actions have not translated into significant improvement in maternal and child health throughout the country. This is manifested in the endemic mortality and morbidity that continued to rise as reported by different scholars (Shiffman & Okonofua, 2006, Bankole et al, 2009, UN, 2007). It is against this backdrop that this paper assessed government health policies, women education and their effect and manifestation on the state of women and children's health in the NDHS of 1999, 2003 and 2008.

Maternal Health Policies in Nigeria

Nigeria's first comprehensive health policy was proposed in 1988- National Health Policy and Strategy to Achieve Health for all Nigerians (1988 National Health Policy) (FGN, 2007). It set a target of "health for all citizens by the year 2000" and recognized primary health care

as defined in the 1978 Declaration of Alma-Ata as an integral part of the 1988 National Health Policy. It also stated that the minimum level of primary health services must include “maternal and child health care, including family planning.” Considering Nigeria’s three-tier system of governance, and noting that the 1979 Constitution placed most health matters on the concurrent list of responsibilities, thereby authorizing the three tiers of government to share responsibilities on matters of health, the National Health Policy (1988) provided for a health-care system with three levels of care: primary, secondary, and tertiary. It assigned responsibility for providing primary health care to the local governments, “with the support of State Ministries of Health”; secondary health care to the state governments; and tertiary health care to the federal government.

Under the Revised National Health Policy (2004), which replaced the 1988 National Health Policy, the provision of three levels of care and division of responsibility for these levels among the three tiers of government, remained applicable. The new policy states that the maternal mortality rate in Nigeria is among the highest in the world and further notes that the government spends only USD 8 per capita on health, despite the international community’s recommendation of USD 34 per capita.

The Policy specifically delineates national standards for reproductive health and aims to “create an enabling environment for appropriate action and provide the necessary impetus and guidance to local initiatives in all areas of reproductive health.” Its objectives include reducing maternal morbidity, unwanted pregnancies, and perinatal and neonatal morbidity and mortality; reducing gender imbalance in matters of sexual and reproductive health; and promoting research on reproductive health issues. In addition, it lists strategies for achieving these goals, such as “equitable access to quality reproductive health services,” building the reproductive health capacity of providers, “ensuring availability of appropriate materials for effective reproductive health services,” and undertaking necessary research to address “emerging issues in reproductive health.”¹⁴ The Health Sector Reform Programme: Strategic Thrusts with a Logical Framework and Plans of Action, 2004-2007 (Health Sector Reform Programme, 2004) was developed to address priority health problems, including maternal mortality. It recognizes the deplorable health status of Nigeria’s citizens, and notes that the nation’s MMR is one of the highest in the world. Moreover, it states that the absence of a clear constitutional mandate for health at the local-government level diminishes the local governments’ obligation to provide primary health care and leaves uncertain the functions of the federal and state governments. The programme also acknowledges the absence of dependable information on the government’s health expenditures and the failure of the people to scrutinize the budgetary allocations in this regard. It notes that the constitutional gaps have obstructed the ability of the government to fulfil its responsibility to provide health care and calls for the enactment of a national health act that would remedy this loophole. In the meantime, the programme recognizes the need to establish primary health-care facilities that are connected to secondary, referral health facilities to ensure access to emergency obstetric care, stating that this would reduce maternal mortality and morbidity. While the 2004 Health Sector Reform Programme identifies many of the problems of the Nigerian health sector and proffers accurate solutions, these problems still persist.

In addition, the Federal Ministry of Health developed the Integrated Maternal, Newborn and Child Health Strategy in 2007 (2007 IMNCH Strategy). The strategy is composed of intervention packages, which address the main contributing factors to maternal, newborn, and child deaths. These packages shift the focus away from fragmented methods of implementing maternal and child health services, to integrated methods. The strategy, which has three stages of implementation—2007-2009, 2010-2012, and 2013-2015—uses primary health care as its main base. Its specific goals include ensuring that 70% of deliveries occur

in health facilities by 2015 and that at least 70% of basic emergency obstetric care will be provided at primary health-care clinics and at general hospitals.

The 2007 IMNCH Strategy recognizes that poverty constitutes a barrier to accessing health and aims to institute a Basic Health Insurance Scheme that would ensure free service to pregnant women, newborns, and children under the age of five. It envisages specific roles for the executive, legislative, and judicial arms of the three tiers of government in its implementation and enjoins the First Lady of Nigeria to serve as the Goodwill Ambassador for women and children and to ensure the implementation of the strategy in the country.

Finally, the 2004 National Policy on Population for Sustainable Development, which replaced the initial policy of 1988, includes the specific goal of “improvement in the reproductive health of all Nigerians at every stage of life cycle. The policy outlines objectives that facilitate reaching this goal, including “expanding access and coverage and improving the quality of reproductive and sexual health care services, increasing and strengthening comprehensive family planning services and safe motherhood programmes, and addressing the reproductive health needs of adolescents. Implementation strategies at all levels of the national health system include:

1. The comprehensive provision of “reproductive and sexual health services that are of good quality, equitably accessible, affordable and appropriate to the needs of all members of the community.”
2. The delivery of reproductive- and sexual-health services as an integral part of primary health care, and of the health-care delivery system at all levels.
3. A strengthened and improved referral system for reproductive health services.
4. The review of all existing laws and policies in order to ensure the protection of the reproductive and sexual rights of individuals, including the right to make decisions concerning one’s reproductive health without coercion, violence, or discrimination.
5. Requiring governments at all levels to ensure “compliance with relevant treaties, policies and laws supporting the attainment of the highest standard of reproductive health services for all citizens.”
6. The development and implementation of a “comprehensive plan for training and retraining of health care providers in integrated and reproductive health service delivery.”
7. Requiring all tiers of government to provide “adequate funding for reproductive health programmes through creation of appropriate budget lines, increased and timely financial contributions, judicious and transparent use of available funds and the implementation of relevant health sector reforms.”

Objectives of the Study

The broad objective of the study is to assess the impact of the different government reproductive health policies on the status of maternal and child health in urban Nigeria.

Specifically, the study assesses:

1. Maternal health policies in Nigeria
2. The educational status of women in the three NDHS
3. Determine whether Antenatal care has improved in the years preceding the latest NDHS.
4. Identify place of delivery and assess whether these places have improve.
5. Assess the level and quality of person(s) who assist women during delivery.

6. Assess the degree of children vaccination in the years preceding the latest survey.
7. Identify perceived problems with assessing health care.
8. Relate maternal education with the status of the variables under assessment.

METHODS

The population covered by the 1993- 2008 NDHS is defined as the universe of all women age 15-49 in Nigeria. A sample of households was selected and all women age 15-49 identified in the households were interviewed.

In the current preliminary census frame, the EAs were grouped by states, by LGAs within a state, and by localities within an LGA. The EAs were stratified separately by urban and rural areas. Any locality with less than 20,000 population in each LGA constitutes the rural area in the LGA.

The primary sampling unit (PSU), a cluster, for the NDHS is defined on the basis of EAs from the 2006 EAs census frame. A minimum requirement of 80 households (400 population) for the cluster size was imposed in the design. If the selected EA was small during the listing process, then a supplemental household listing was conducted in the neighbouring EA. The number of clusters in each state was not allocated proportional to their total population (or households) due to the need to obtain estimates for each of the 36 states and FCT-Abuja. Nigeria is a country where the majority of the population resides in rural areas. With the current allocation, the urban areas in some states were over-sampled in order to provide reliable information for the total urban population at the National level.

Based on the level of non-response found in the 2003 Nigeria DHS, to achieve this target, approximately 36,800 households were selected, and all women age 15-49 were be interviewed. A requirement was to reach a minimum of 950 completed interviews per state. In each state, the number of households was distributed proportionately among its urban and rural areas. The selected households were distributed in 888 clusters in Nigeria, 286 clusters in the urban areas, and 602 clusters in the rural areas. Under this final allocation, it was expected that each of the 36 designated states and FCT-Abuja would have a minimum of 950 completed women interviews The 2008 NDHS sample was selected using a stratified two-stage cluster design consisting of 888 clusters, 286 in the urban and 602 in the rural areas. Once the number of households was allocated to each state, the numbers of clusters (calculated based on an average sample take of 41 completed interviews or about 41 selected households) was calculated by dividing the total sample in the state by the sample take. Finally, all women 15-49 years were interviewed in each cluster, and in half of the selected households about 20 men were interviewed. Before the selection in a state, all EAs were stratified by urban and rural areas.

The analysis involved univariate and bivariate analysis.

RESULTS

This section presents data on the educational status of women in the urban and rural areas of Nigeria and the selected variables directly related to maternal and child health.

Table 1: Educational Status of Women

NDHS	Percentage Level of Education				
	No Education	Primary	Secondary	Higher	Don't know
1999	25.4	32.0	29.9	8.1	4.6
2003	31.9	30.9	29.4	6.8	1.0
2008	22.0	30.5	34.7	11.4	1.5

A comparative assessment of the educational status of women is crucial in determining the outcome of other variables. This is because education is a change agent and a higher educational qualification brings about change in the health seeking behaviour of women. Data on women's education show that there was only marginal improvement in the educational status of women in the period under review. It is instructive that between 1999, which forms the baseline for assessment, women with higher educational qualification rose from an all time low 6.8 percent in 2003 to a little over eleven percent. The women without any form of education did not change markedly, yet there is a drastic reduction of women with secondary educational qualification from 32.0 percent in 1999 to 30.5 percent in 2008. It follows that the marginal improvement cannot make any appreciable impact on the other variables that depend on education for improvement.

Table 2: Selected variables for Maternal and Child Health

Antenatal Care Attendance											
NDHS	Place of Antenatal Attendance										
	Doctor	Nurse/auxiliary/ Midwife			Comm/health work	TBA	Other	No one	Missing		
1999	40.1	43.4			Na	3.0	Na	10.3	3.2		
2003	38.5	44.2			0.3	1.5	0.1	15.0	0.2		
2008	41.8	42.1			1.1	2.2	0.6	11.8	0.4		
Place of Delivery											
NDHS	Any fac	Public	Private	Home	Other	Missing	% del in health fac				
1999	Na	52.2	0.0	42.2	0.0	4.0	27.7				
2003	14.2	28.5	25.6	44.8	0.5	0.5	28.9				
2008	-	30.9	28.5	35.9	3.6	1.0	29.7				
Assistance Received During Delivery											
NDHS	Doctor	Nurse/midwife			Com worker	TBA	Relative	No one	Missing		
1999	14.0	43.9			-	15.5	14.2	9.6	2.8		
2003	14.1	44.4			0.3	11.6	17.9	10.6	1.0		
2008	20.3	39.5			5.6	13.1	11.2	9.0	1.3		
Vaccination of Children											
NDHS	BCG	DPT			POLIO				MEASLES	ALL	NONE
		1	2	3	0	1	2	3			
1999	75.0	70.4	60.0	44.7	41.7	75.7	64.9	41.8	61.5	31.7	19.6
2003	70.	63.5	51.3	40.2	40.2	75.3	64.4	42.0	52.1	25.1	16.7
2008	71.4	71.3	64.5	54.8	57.2	77.6	68.4	51.6	59.1	37.5	17.9

Table 3: Educational Qualification and Utilization of Maternal and Child Health

Category	Education Qualification				Total	χ^2	Df	P<.05
	No Edu	Prim	Sec	Higher				
Antenatal attendance	167	336	883	435	1821	786.224	3	.000
Doc	9.2%	18.5%	48.5%	23.9%	100.0%			
Nurse/	601	639	1120	389	2749	98.849	3	.000
Midwife	21.9%	23.2%	40.7%	14.2%	100.0%			
Auxillary/	96	108	173	48	425	8.572	3	.037
Midwife	22.6%	25.4%	40.7%	11.0%	100.0%			
TBA	39	35	54	2	130	23.726	3	.000
	30.0%	26.9%	40.5%	1.5%	100.0%			
Comm/Villa	28	20	31	3	82	9.261	3	.026
Healthwork.	34.1%	24.4%	35.8%	3.7%	100.0%			
Other Respondent	7	8	22	1	38	9.104	3	.022
	18.4%	21.1%	58.0%	2.6%	100.0%			
No care: No	863	738	1706	619	4126			
Some care	20.9%	17.9%	41.3%	15.0%	100.0%			
Yes	451	126	97	4	678	642.277	3	.000
No Care	66.5%	18.6%	14.3%	.5%	100.0%			

Antenatal care ensures optimal health outcomes for mothers and baby. Antenatal care from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery. Data on antenatal care attendance showed that more than 11 percent of women, up till 2008, were not attended to by anyone, while less than half of the women were attended to by a doctor. The percentage of women who were not attended to by a trained health provider in 2008 was 14.6 percent while in 1999, there were only 13.3 percent showing that there was no improvement in urban maternal antenatal care attendance in the period under review. Educational qualification plays a very dominant role in the uptake of antenatal services. Though the uptake of maternal health services is generally poor, it is obvious from the table that those who were better educated took up the health services better. Those with secondary and higher education took up better antenatal services like a doctor and trained nurse far and above the other levels of education. For

instance, those with secondary and higher education had over 30 percent of maternal health with doctors while others had less than 20 percent

Table 4: Educational Qualification and Place of Delivery

Category	Educational Qualification							
Place of Delivery	No Edu	Prim	Sec	Higher	Total	X ²	Df	P<.05
Home	945	397	264	30	1636			
	57.8%	24.3%	16.1%	1.8%	100.0%			
Other home	38	76	126	10	250			
	15.2%	30.4%	50.4%	4.0%	100.0%			
Govt. hospital	202	212	525	263	1202			
	16.8%	17.6%	43.8%	21.8%	100.0%			
Govt. health center	64	110	178	47	399			
	16.0%	27.6%	44.6%	11.8%	100.0%			
Govt. health post	2	1	9	0	12	161.26	24	.000
	16.7%	8.3%	75.0%	.0%	100.0%			
Other public clinic	4	4	13	4	25			
	16.0%	16.0%	52.0%	16.0%	100.0%			
Private hosp/clinic	51	211	589	254	1105			
	4.6%	19.1%	53.3%	23.0%	100.0%			
Other private medical centres	3	11	16	5	35			
	8.6%	31.4%	45.7%	14.3%	100.0%			
Others	8	43	86	10	147			
	5.4%	29.3%	58.5%	6.8%	100.0%			

Increasing the percentage of births delivered in health facilities is an important factor in reducing deaths arising from the complications of pregnancy. The expectation is that if a complication arises during delivering, a trained health worker can manage the complications or refer the matter to the next level of care. Data on place of delivery showed that a majority of deliveries in urban areas of Nigeria during the period preceding the survey took place outside a health facility. This trend did not really change from 1999 to 2008. Almost 40 percent of deliveries took place at home in 2008 and this trend had been there from the 1999 survey. Again, the total percentage of deliveries that took place in a health facility remained abysmally low from the 1999 survey to the one in 2008, with 27.7 percent, 28.9 percent, and 29.7 percent respectively. This is an infinitesimal improvement that does not rub off on the status of women and children's health outcome in the country. Controlling for

educational qualification, though the place of delivery is generally poor but those with secondary and higher educational levels were delivered by a trained personnel ranging from a doctor to a nurse. These variables also showed significant relation at the .05 alpha level.

Table 5: Educational Qualification and Assistance Received During Delivery

Category	Educational Qualification					X ²	Df	P<.05
	No Edu	Prim	Sec	Higher	Total			
Doctor	64 7.0%	143 15.5%	441 47.9%	272 29.6%	920 100.0%	481.39	3	.000
Nurse/ Midwife	298 12.4%	500 20.8%	1141 47.5%	465 19.3%	2404 100.0%	705.354	3	.000
Auxillary/ midwife	56 14.4%	89 22.9%	193 49.7%	50 12.9%	388 100.0%	46.036	3	.000
TBA	351 48.1%	176 24.1%	189 25.9%	13 1.8%	729 100.0%	274.714	3	.000
Relative/ Friend	273 51.5%	183 34.5%	86 16.2%	8 1.5%	530 100.0%	322.207	3	.000
Other Respondent	28 30.8%	25 27.5%	34 37.4%	4 4.4%	91 100.0%	8.520	3	.036
No one: No	1021	994	1741	65	4371	376.04	3	.000
Some Assist	23.4%	22.7%	39.8%	1.5%	100.0%			
Yes	2900	70	60	7	3037			
No Assist.	95.5%	2.3%	2.0%	.2%	100.0%			

In addition to the place of birth, assistance during childbirth is an important variable influencing the birth outcome and the health of mother and infant. The skills and performance of the person providing assistance during delivery determine whether complications are managed and hygienic practices are observed. Data on assistance during delivery has not improved despite government policies. In fact, assistance given by Traditional Birth Attendants (TBAs) rose from 11.6 percent in 2003 to 13.1 percent in 2008 while assistance by a doctor is about 20 percent within same period. Generally, assistance in the periods preceding the surveys was predominantly given by non-professionals. Only qualified personnel attended to a marginal number of women. However, the bivariate analysis show that while the place of delivery has not changed markedly, yet those with higher educational qualification had a slightly more advantage over those less education.

For instance, the percentage of those who were attended to by a doctor and a nurse is over forty for those with secondary education and higher.

Table 6: Educational Qualification and Vaccination of Children

Vaccination Received	Education Qualification					X ²	Df	P<.05
	No Edu	Prim	Sec	Higher	Total			
BCG	155	315	758	318	1546	1112.4%	12	.000
	10.0%	20.4%	49.0%	41.0%	100.0%			
DPT 1	140	302	697	297	1436	940.020	12	.000
	9.7%	21.0%	48.5%	20.8%	100.0%			
DPT 2	101	250	615	280	1246	988.332	12	.000
	8.1%	20.1%	49.4%	22.5%	100.0%			
DPT 3	78	209	535	225	1017	869.934	12	.000
	7.7%	20.6%	52.6%	22.1%	100.0%			
Polio 1	139	290	673	293	1395	470.252	12	.000
	10.0%	20.8%	48.2%	21.0%	100.0%			
Polio 0	126	229	663	290	1358	904.407	12	.000
	9.3%	16.9%	48.8%	21.4%	100.0%			
Polio 2	94	235	587	271	1187	627.673	12	.000
	7.9%	19.8%	49.5%	22.8%	100.0%			
Polio 3	74	196	495	241	1006	440.808	12	.00
	7.4%	19.5%	49.2%	24.0%	100.0%			
Measles	70	155	362	185	772	470.22	12	.000
	9.1%	20.1%	42.2%	24.0%	100.0%			
Ever had vaccination	535	465	759	248	2006	309.463	12	.000
	26.7%	23.2%	37.8%	12.4%	100.0%			

The World Health Organisation considers a child to be fully vaccinated if he or she has received a BCG vaccination against tuberculosis, three doses of DPT vaccine and one dose of measles vaccine. These vaccinations should be received during the first year of life. The trend of vaccinations in the period preceding the three surveys show only a marginal improvement for some and a reduction in others. For instance, 75.0 percent of children were given the BCG vaccine in 1999 but only 70.1 percent and 71.4 percent were given in 2003 and 2008 respectively. Besides, only 37.5 percent of children received all vaccination in 2008. This is an indication that a majority of children are being left out in the immunization programme of the government.

The perceived problems in accessing health care are important in understanding and addressing the barriers women may face in seeking care in general. The 1999 survey did not capture this but it was captured in the 2003 and 2009 survey. Almost half of the women cited at least one problem in accessing health care. The problems indicated include- where to go, getting permission to go, getting money for treatment, distance to the health facility, availability of transport, not wanting to go alone and concern that there may not be a female provider. The most common problem was getting money for treatment followed by distance to health facility and having to take transport. Less than one in five women reported the other three problems. However, the concern for no drugs available was the commonest problem reported to be affecting women's access to health services.

DISCUSSION OF FINDINGS

Health Policies and Maternal Health

The study found that despite lofty health policies formulation there is a serious lack of commitment to implementing these policies as can be seen in the gross under budgeting of the health sector over the years.

The findings of this paper are in line with several observations that have been made by different organizations and scholars on Nigeria's slow movement towards the achievement of the MDGs. This assertion was aptly captured in the midterm assessment of the MDGs in Nigeria. The progress made was reported thus (FRN, 2007).

The emerging trend in child mortality is of great concern at this mid-point of goal achievement period. Infant mortality rate actually rose from 81 per 1000 live births in the year 2000 to 110 per 1000 live births in 2005/2006, which is farther away from the global target of 30 per 1000 live births in 2015. Besides, the target percentage of one year olds fully immunized is expected to be total; so far, the proportion only increased from 32.8 percent in 2000 to 60 percent in 2007. This slow pace has accounted for the increase in avoidable disease such as polio. Polio cases rose from 201 in 2007 to 651 cases in 2008. With this, Nigeria has 86 percent of the total number of polio cases in the world (FRN, 2007).

On maternal health, the midterm assessment maintained that

reduction of maternal mortality represents a major challenge for Nigeria. Mid way to the target date for achieving the MDGs, the maternal mortality rate should be 440 per 100,000 live births. The reality however shows that in the urban areas, there are 531 deaths per 100,000 live births. Approximately, two thirds of Nigerian women deliver outside of health facilities and without medically skilled attendance present (FRN, 2007).

Women Educational Status and Maternal/Child Health

Strikingly, the findings of this study showed that though there are several government policies and programmes that are geared towards improvement in health services generally and maternal and child health particularly. What is on ground shows that these policies are not either implemented properly or not implemented. Several scholars have drawn the attention of government and other agencies to the poor state of health infrastructure in the country, which contributes directly to the observed poor maternal and child health outcomes. These infrastructure range from inadequate skilled manpower in the hospitals and primary health centres, poor motivation system, inadequate funding, poor management of the health sector resources, weak transparency and accountability framework in the sector.

It is as a result of the slow pace at improving maternal and Child health that the MDGs 4 and 5 to reduce child and maternal mortality by 75 percent and to achieve universal access to reproductive health by 2015 has made the least progress of all MDGs. Things therefore need to be done properly to change the ugly trend.

While many proven, cost-effective ways to save the lives of mothers, newborns, and children exist, they are not always available to those who need them most. Historically overlooked by both safe motherhood and child survival policies and programmes, newborns continue to lack access to cost-effective lifesaving interventions. The Bellagio Study Group on Child Survival estimates that universal coverage (99 percent) of 16 proven newborn health interventions could avert up to 72 percent of all newborn deaths (Fotso & Ezeh, 2009). These include interventions such as tetanus toxoid immunization, skilled attendance at birth, access to emergency obstetric care, immediate and exclusive breastfeeding, drying and keeping the newborn warm, and if needed, resuscitation, care of low birth weight infants, and treatment of infection. The series estimates that 63 percent of child mortality would be prevented with 99 percent coverage of effective and available interventions (Gareth et al, 2006). In addition to newborn interventions, safe water and good sanitation; immunizations; management of diarrhoea, pneumonia, and malaria; appropriate feeding practices; and access to care could significantly reduce child mortality.

The World Bank has estimated that 74 percent of maternal deaths could be averted if all women had access to interventions that address complications of pregnancy and childbirth, especially emergency obstetric care (Adam, & Claeson, 2004). The package of interventions that would prevent these deaths includes good nutrition; access to family planning; care during pregnancy, delivery, and the postpartum period; and referral services for complications.

In developing countries, a mother's death in childbirth means that her newborn will almost certainly die and that her older children are more likely to suffer from disease. Moreover, when mothers are malnourished, ill, or receive inadequate care, their newborns face a higher risk of disease and premature death²². Almost one-quarter of newborns in developing countries are born low birth weight, largely due to their mothers' poor health and nutritional status, which results in increased vulnerability to infection and a higher risk of developmental problems. The quality of care that both mother and newborn receive during pregnancy, at delivery, and in the early postnatal period is essential to ensuring women remain healthy and that children get a strong start. Many stillbirths and newborn deaths could be averted if more women were in good health, well-nourished, and received quality care during pregnancy, labour and delivery, and if both mother and newborn received appropriate care in the postpartum period (Tinker, et al, 2005, Tinker, 1997, Martines et al, 2005).

Health policies and programmes in the fields of maternal, newborn, and child health, have generally focused on one issue alone—targeting interventions to only one of these groups and obscuring important linkages. When approached together and incorporated into integrated programmes, these interventions could save millions of lives at a lower cost than separate initiatives. Linking interventions in packages can reduce costs by allowing greater efficiency in training, monitoring and supervision, and use of integrated systems. Finally, *The Lancet* Neonatal Survival Series emphasized the importance of the concept of a continuum of care while focusing on saving newborn lives.

The newborn is increasingly being recognized as the vital link between mothers and children. This acknowledgment coincides directly with greater recognition of the importance of the continuum of care. The next step is to apply this understanding in policies and

programmes. India, for example, has developed a strategy to reach newborns as well as older children and reproductive aged women, through home and facility-based care²⁵. Similarly, the government of Ethiopia is in the process of incorporating the newborn into existing programmes and policies and is working with the Partnership for Maternal, Newborn, and Child Health to improve MNCH services through a continuum of care.

The Nigerian government must be willing to commit adequate resources to meet the needs of the health system. The system must be significantly overhauled to promote proper co-ordination among the three levels of government-federal, state and local to reduce bureaucratic bottlenecks and wastage of resources.

Periodic monitoring of development with regards to maternal health should be conducted every three to five years. Auditing of facilities needs to be institutionalized to assess every case of maternal morbidity and mortality. Active partnership between government and private sector should be encouraged and vigorously pursued to bring about an effective collaboration for better maternal health services in both private and public health sectors.

In recognition of the fact that a large proportion of births take place with Traditional Birth Attendants (TBAs) and the realization that marginal efforts in the past in training them had only marginal success, government should review the training and related facilities to situate TBAs properly in order to improve the quality of care given by them. Since there is a low level of awareness about pregnancy related problems and a poor health seeking behaviour recorded, substantial attention needs to be devoted to behaviour and attitudinal change through communication programming for maternal and neonatal health promotion for morbidity and mortality reduction (Ugabi & Ugal, 2009 & Ugal, 2010).

Conclusion

This study was undertaken to assess the state of maternal and child health in Nigeria using data from the NDHS, in response to the unacceptably high death rate of mothers and their children in Nigeria. The study found that education as a change agent did not markedly change within the period but its marginally upward change did not affect other variables under consideration. Antenatal care and assistance during delivery remained unchanged.

Following from here, the need to vigorously improve and change the attitude of women towards maternal health services is suggested while holding government responsible for the poor health infrastructure in the country.

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Seeking advice about children's health in an online parenting forum

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INTRODUCTION

There has been considerable interest in recent years in the subject of online health information. Research has largely focused on how people use the internet for advice on self-management of symptoms, to clarify information they have been given about diagnoses, or to seek more detailed information than they have been given by a professional (McMullan 2006). Less visible is the provision of health-related advice and social support through online networks, although there is growing interest in the sociological literature (Nettleton et al 2002). A review of literature on internet social support in health identified the availability of online support for example for people with cancer and diabetes; carers of people with Alzheimer's disease; and mothers of children with disabilities (Scharer 2005). These support sites are often excluded from evaluations of health information online (Sillence et al 2006) and so less is known about the type of information and advice that is available and how it is being used. Targeted online social support seems to be more readily available for people with serious or chronic illnesses and for parents of children with disabilities or special needs than for those who are dealing with everyday illnesses in children. However instead of, or as well as, using dedicated health sites, people can access information and support via topical message boards or chat forums on websites which do not necessarily have a health focus. There has been a recent increase in interest in the use of websites as sources of advice and support for parenting (O'Connor & Madge 2004; Madge & O'Connor 2006; Plantin & Daneback 2009), and this can include advice around children's health.

Online support bears many similarities to that offered by more traditional face-to-face support groups. In particular, face-to-face groups are thought to value the experiential knowledge of members (Kelleher 1994). The concept of experiential knowledge was in fact originally introduced as a way of theorising self-help groups and was defined as 'truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others' (Borkman 1976: 446). Burrows and Nettleton (2002:265) have noted this privileging of experiential knowledge in the online context. Support groups also offer a mixture of opinions and advice, and equally a study of bulletin boards found that the most useful responses contained 'personal opinions, actionable advice, and concrete information' and, where appropriate, urged users to seek professional medical help (Suzuki & Calzo 2004: 696). This encouragement to seek help is an example of what Freidson termed a 'lay referral system', that is 'a network of personal influence along which the patient travels on his [sic] way to the physician' (Freidson 1960: 374). These concepts of experiential knowledge and lay referral provide a useful starting point for understanding the advice available in online forums.

This paper emerged from preliminary research as part of a study about the illness behaviour of callers to NHS 24 (a Scottish telephone-based service which provides health assessment, advice and, where necessary, referral to other services in the out-of-hours period). When

exploring how people make decisions about use of health services I began to read discussions involving lay referral to NHS 24 on the UK parenting website Mumsnet. It became clear that the website is a significant source of health advice, information and support for many of its users, and that as well as lay referral to out-of-hours health services, parents were offering each other a wide range of advice based largely on experiential knowledge. This paper will outline how online peer support and advice is accessed by parents in making day-to-day health decisions for their children. Specifically it will look at three forms of advice: to seek medical help; to push for access to further or specialist care; and to self-care. In discussing these examples I will note the strength of lay referral networks and the weight that seems to be given to experiential knowledge in this online community.

MUMSNET

Mumsnet is a website which was set up in 2000 by two mothers as a forum for parents to share information. The site gets nearly 5 million visits each month and has, according to political commentators, developed huge political influence across all parties in the UK (Phillips, *Total Politics* 2012). It was described by former prime-minister Gordon Brown as a 'national institution' and despite the fast pace of change in cyberspace, 'Mumsnet's capacity to hold decision-makers to account shows no sign of fading' (Henderson, *BBC News* 2011).

However it must be noted that the site has been criticised in the press as being unrepresentative of the majority of parents (Young, *The Telegraph* 2011) and indeed a 'Mumsnet census' of more than 5,000 users carried out by the site in 2009 showed that the majority of users (63%) are between 31-40 years old; female (98%) from the UK (95%)-mainly the south-east; and have children under 6 years old. 75% were educated to at least degree level and 94% identified their ethnicity as white. Most were married or living with a partner (94%) and only 10% had an average household income of less than £20,000 per annum (Mumsnet census 2009). This presents a picture of a group of well-educated, middle class mothers rather than a cross-section of parents in the UK. Pedersen and Smithson (2013) have argued that Mumsnet is in many ways atypical of online parenting communities, and that this is in fact part of its appeal to users. In response to a question about reasons for using Mumsnet, 76% of respondents to the census said that they use it for advice and 75% said for information (Mumsnet census 2009).

In many ways, the Mumsnet community can be likened to a self-help group in that members turn to each other for advice, support, reassurance and practical advice based on experience. Some of the anonymous user comments in the Mumsnet census give an insight into the sort of support network that Mumsnet provides, with people referring to it as a 'sisterhood' or 'just like my mum - occasionally prickly and infuriating but generally an informative, hilarious and pivotal part of my life. And always there when I need it' (Mumsnet census 2009). This perception of the site as a supplement to (or possibly substitute for) familial support is reinforced by accounts of what users feel it provides for them: 'It's a lifeline for me as a new mum, giving me advice, information and diversion. It's allowed me to figure out what kind of parent I want to be, confident in the knowledge that there are a million different ways to do it, each as valid as the other' (Mumsnet census 2009).

'Mumsnet Talk' is the discussion forum on the site. It gets about 25,000 posts each day. Discussions cover a wide range of topics such as pregnancy, childcare, education, travel, food, politics and health. Within the health section, discussions are categorised as: allergies; child/ adolescent mental health; children's health; family planning; general health; life-limiting illness; menopause; mental health; swine flu; and vaccinations. As is clear from the categories, parents use the forum to discuss their own health as well as their children's

health. The advice and information shared is as varied as the questions asked and represents a diversity of perceptions of health and models of healthcare from technological interventions to home remedies and alternative or complementary therapies. The open and largely unmoderated nature of the forum allows opinions and ideas to be challenged and for a range of opinions to be represented.

METHODS

I focused my attention on the 'Children's Health' section of Mumsnet Talk and used the search term 'NHS 24' to identify discussions which may be of relevance to my research. Searching from 2002-2012, (the first ten years of NHS 24's existence in Scotland), returned 278 discussion threads. For the purpose of this paper, I reduced the search parameters to one year- from September 2011 to September 2012- the most recent year at the time of analysis. This returned 42 threads, of which 8 did not actually mention NHS 24 and were discounted. This left 34 discussions, containing a total of 823 individual posts. These posts were copied, analysed and coded thematically with the aid of NVivo software (QSR International, UK). This approach has been described as a combination of document analysis and 'a form of observation' where 'naturally occurring interaction between the forum members' can be witnessed without intervention (Turkmendag et al 2008: 293-4).

There are challenges in the use of internet discussion forums for social research, including methodological and ethical challenges (Wilson & Peterson 2002; Hamman 2004). However, collecting data from online communities has become more common as researchers have grown aware of the advantages, such as being able to observe real interactions in a non-obtrusive way (Pacagnella 1997). Much of the debate around ethics in online research is centered on three main issues: the definition of public and private spaces; informed consent; and anonymity (Knobel 2003: 190). I gave these issues careful attention and followed guidelines from the Association of Internet Researchers (AoIR 2002) which advise consideration of website users' likely perceptions of how public their discussions are. The distinctions between public and private domains are blurred in interactive online media and ethical considerations are often, by necessity, context-specific (Snee 2008). Mumsnet Talk forums are publicly visible, even to non-members of the site, and as this is stated clearly on the site the discussions can be seen as public (Rodham & Gavin 2006; Hine 2012) - although I am aware that this is a contested position (Berry 2004). The issue of informed consent is also problematic, as I was looking at archived discussions from up to a year ago in which participants use pseudonyms and do not provide contact details. In addition, 'assurances of participants' anonymity in research reports are deeply problematic in the archived and searchable network of cyberspace' (Knobel 2003: 188). All posters on Mumsnet use a pseudonym and are not identifiable from their posts. Despite this, I have not attributed remarks to contributors' pseudonyms in this paper out of respect for their online identities (Pacagnella 1997; Knobel 2003; Hine 2012).

The discussions I looked at ranged from simple questions with one or two straightforward responses, to lengthier conversations including one thread which was active for almost a month. In analysing these discussions I identified a range of issues which led parents to seek advice from the Mumsnet community. In this paper I focus on three forms of advice which were commonly given: to seek medical help; to push for access to further or specialist care; and to self-care. These examples were chosen for their relevance to my interest in how lay consultations impact on help-seeking behaviour. They provide some insight into how lay referral and the exchange of experiential knowledge are performed in reports of real-life situations.

FINDINGS

Advice to seek medical help

In the discussions analysed, parents frequently encouraged each other to seek professional care. This included advice to contact NHS 24, NHS Direct (as it was then), the local out-of-hours service, a GP, or to go to a hospital Emergency Department. To an extent the advice varied depending on the time of day and the perceived seriousness of the situation. However as Mumsnet is used by people all over the UK, it also to some extent depended on what services were available in the poster's own area. For example, NHS 24 and NHS Direct were used almost interchangeably, and in the out-of-hours period it was sometimes unclear if advice to 'call OOH' meant to call NHS 24/ Direct or to contact the local out-of-hours GP service.

In an example of how lay referral is enacted on Mumsnet, one mother posted a message asking what to do about a six week old baby with a temperature of 38 degrees. She had only used a crude strip on the forehead and wanted advice on how to get a more accurate temperature. There was nothing obviously wrong with the baby, he was 'just a bit off' and had sneezed a couple of times. She said:

I can hardly look at him for fear, he's so little and how can I tell if he's sick?

Within an hour there had been 18 replies, most of which advised the mother to seek medical advice from NHS Direct or NHS 24, the Out of Hours service or a GP. Respondents frequently phrased their advice in terms of what they would do themselves in a similar situation:

I'd ring for NHS for advice if I was you. He is very young and better safe than sorry.

I'd get off Mumsnet and call nhs 24 now if I were you.

One person replied by supplying a link to an NHS website, and posting the relevant guidelines on temperature in small babies which suggested that medical advice should be sought, and one person stated that they were a paediatrician and would also advise a consultation. However most people who responded did not declare any medical knowledge and seemed to be basing their advice on a feeling that the age of the baby meant the mother should not take any chances:

If you are worried then phone out of hours - you don't want to mess around with a tiny baby.

Respondents sometimes offered their own interpretations of symptoms and possible diagnoses based on their own experience and that of people they know. This often emphasised the potential seriousness of the situation and thus justified their insistence that professional care should be sought.

I've always been told to add a degree to underarm temp. I would call OOH GP now if I were you. My [daughter] had this last weekend, same age and it was bronchialitis [sic] and a chest infection. You also say his soft spot is sunken, this is a dangerous sign.

The following morning the opening poster replied to say that she had brought the baby to the GP the night before and that everything was fine. She added:

Thanks for spurring me to act last night. Fear tends to paralyse me

In this case lay referral had encouraged and legitimised help-seeking, in an example of what has been termed by Zola (1973) as 'sanctioning'.

Advice to push for access to further or specialist care

In a study about lay peoples' use of online health knowledge, 'a number of participants reported that they had renegotiated treatment for themselves or their children with their GP on the basis of information they had found on the internet' (Hardey 1999:829). Equally on Mumsnet worried parents are frequently encouraged to challenge practitioners and to attempt alternative routes to care if they are not satisfied with what they are told. This can include advice to seek a second or specialist opinion, or to demand attention and recognition of their fears.

One mother posted a message asking how long she should wait before phoning the out of hours service about her 2 year old son who was constipated and in pain. She wasn't sure if the problem was even 'doctor worthy' at all. It had been going on for a couple of days and the child was lethargic and shivery. As in the example above, many of the responses advised the poster to seek medical advice, and again they emphasised the potential urgency of the situation based on experience:

I would take him to OOH. He may need a glycerine suppository/ lactulose/ some numbing cream to help him pass it - my [son] had something similar when he was 2.5, and it caused us problems for months as he got a tiny fissure when he eventually passed it, and it scared him so much he ended up chronically constipated. I don't mean to scare you, but it might be best to see someone. Hope he's all sorted soon.

In this case the mother did phone the out of hours service the next day (Sunday) and the child was seen by a paediatrician and given a prescription. She also took him to her own GP on Monday. She continued to update on the child's progress and by Tuesday there was no obvious improvement. At this point, others began to suggest that she should ask for further assessment:

Maybe he is impacted higher up, I think I would bring him back to GP as they really should scan him to check.

I would ask your GP to arrange for you to be seen at your local children's dept today. It has gone on for too long now, for both of you. [...] Maybe he needs to be assessed by a paediatrician again.

The discussion continued over the following ten days, with the opening poster updating on progress but remaining worried that the problem was not resolving. At this stage the advice to seek access to more specialist help was stronger:

I think you need to bring him back again to hospital, they need to find the reason for this[...] Bring him to hospital and demand they do a scan and investigate this further.

I'd just go and sit in a&e with him, refuse to move till he's been scanned and they can help make him more comfortable.

There should be a constipation and soiling service in your area, and he needs assessing by them. I think he may need assessing by a paediatrician, if you do need to go back to A/E, then ask to see a paed.

The opening poster was ambivalent about this advice:

God! Do you all really think so?? At this rate he'll be traumatised by doctors. We'd be hours waiting too. Might ring nhs direct and see what they say. Will be OOH again though, it always is with a child. Our OOH is in the hospital. Last time saw nurse practitioner only. Could insist on seeing a doctor I suppose. [...] A&E though? Really?

Again one parent reinforced their advice to persist in seeking care based on experience:

My daughters both grew out of it but both had very bad phases, [eldest daughter] was under the hospital for it and it lasted about 2yrs, [younger daughter] was just under the doctor as I was much more forceful with them and had experience and hers lasted 8mths.

This suggestion here that being 'forceful' resulted in a better outcome for a child supports the idea that being persistent in seeking care is the right thing to do. In the context of internet use in parental decision making, Burrows and Nettleton have suggested that:

Parents are not prepared to accept uncritically the views and advice of health professionals or the results of studies which are published in learned scientific journals. They are keen to seek advice from a range of sources and listen to the views of other non-professionals whose observations are based on experiential "evidence" (Burrows & Nettleton 2002: 262).

A readiness to challenge professional expertise on the basis of experiential knowledge is apparent on Mumsnet.

Advice to self-care

'Self-care' is a term that has not been clearly defined in theoretical literature (Wilkinson & Whitehead 2009). It is most commonly used in relation to the management of chronic illness, but here it is used to mean taking measures to treat symptoms at home without seeking a medical consultation. A study by Porteous and colleagues (2006) found that self-care was respondents' preferred method of managing minor illness, and it is well-recognised that the majority of symptoms do not lead to a medical consultation (Hannay 1979).

The longest thread in the sample of discussions was started by a mother who asked for advice on how to ease the itch of chicken pox. It was generally recognised by those who responded that this was not something for which parents should seek medical attention; in fact parents actively discouraged each other from going to GP waiting rooms where there may be vulnerable or immune-suppressed patients. Instead, parents shared tips on how to manage the illness at home, including the best creams and lotions to use:

Pharmacist recommended Eurax to [husband] but don't know if it's any good cos [daughter] wouldn't stand still long enough to apply it! So back out for poxclin it's miracle stuff smeared on in seconds all over body bit longer to soak in. [Daughter] said it wasn't too bad never one to admit mummy knows what she is doing. No itching though and no screaming about it stinging like with the calamine and Eurax. She also managed some sleep which is good.

However, in this thread there was quite a lot of discussion about the inefficacy and expense of some pharmaceutical remedies, and while many parents did advocate the use of particular creams and lotions, there was also considerable sharing of non-medical tips and remedies for dealing with the illness. As in previous examples, parents drew largely on their own experience in advising others.

I was advised to use virasoothe by the pharmacist but it didn't help at all. On day 3 she was so itchy and uncomfortable even after a dose of piriton I decided to try Lanes tea tree and witch hazel cream on each spot (I had some left over from treating my son's Molluscum Contagiosum) put some tea tree face wash in her bath. Worked instantly!

Porridge oats in the bath worked great for us. Put them inside an old pair of tights. You can then use it to bathe them too.

Get loads of tubs of bicarb also brilliant in the bath. When [daughter] had it terribly we spent a few nearly whole days with her in the bath watching dvds on the laptop.

Of the threads looked at in this study, this is the discussion which most resembled a 'support group' as it continued for over a month, and many parents whose children were suffering from chicken pox joined in, updating each other on progress, advising each other about what symptoms to watch out for and sharing what treatments and distraction techniques were working well for them.

However, even this discussion was not completely free from mentions of risk, and it was clear that some parents didn't feel confident in diagnosing and treating the illness themselves. One mother whose daughter had been quite unwell and feverish with chicken pox wrote:

I read a terrifying article about a little boy who died from chicken pox because the parents thought he would get better and were fobbed off repeatedly by their GP's receptionist and he developed pneumonia. It was too late by the time he was treated in hospital.'

Others responded to the mother advising her to call her GP or NHS Direct if she was worried, and not to Google any more stories about chicken pox.

Discussion: Parental decision making and online support

Decision-making around caring for a sick child is not straightforward and many parents go through a range of actions such as home care, using over the counter remedies and seeking peer advice before accessing formal health care, as has been discussed by Cunningham-Burley and Irvine (1987) and Houston and Pickering (2000). In those studies, mothers were keen to take responsibility for their children's health themselves and the decision to call a doctor was not taken lightly. They learned from experience of previous illnesses and generally recognised themselves as experts in their children's health. However, Houston and Pickering noted the impact of fear on decision making when dealing with a sick child and how parents' usual confidence and coping abilities could be undermined, leading them to worry about whether they were 'doing the right thing'. This indecision and worry can be seen in some of the discussions on Mumsnet, along with concerns about burdening health services, and an awareness that by seeking medical advice one may be labelled as an 'over-sensitive mother'. A further consideration when deciding to seek care is a concern not to submit children to unnecessary medical attention, as expressed by the mother of the constipated toddler who she feared would be 'traumatised by doctors'. Houston and Pickering also recognised 'the social isolation of looking after a sick child' (Houston & Pickering 2000:239) and the importance of support from family, friends and neighbours. The parents posting in the thread about chicken pox frequently commented on how grateful they were for the support available on Mumsnet, especially as many of them were reluctant to go out in public or to see friends and family while their children were contagious.

It is clear from reading discussions on Mumsnet that for some parents it is the first port of call for advice when making decisions about their children's health. This raises an interesting question as to why this might be. Although there are healthcare professionals who are members and occasionally post advice in a professional as well as peer capacity, the majority of users are not medically trained. It has been suggested that the nature of the internet blurs the boundaries between lay and professional audiences, and that the unregulated space of the internet allows diversity in the models of health about which information is available (Hardey 1999). A site like Mumsnet allows space for the sharing of lay knowledge about self-care and alternatives to medical treatment, as well as first-hand

experience of medical care, including specialist care. The parents who offer advice are drawing on an attractively diverse range of knowledge; personal and professional, derived from their own experiences and those of others. The way that an online forum allows people to access a broad range of opinion is similar to that described by Borkman in relation to face-to-face support groups:

By pooling the experience of a number of people, the common elements of the problem and attempts to cope with it emerge, while simultaneously highlighting the uniqueness of each individual's situation. Consequently, the individual learns how his [sic] problem is both similar to and different from that of others, which forces him to utilize the knowledge selectively to fit his situation. Similarly, the group is protected against inapplicable knowledge that is too idiosyncratic or peculiar because a number of people rather than just one or two persons are pooling their knowledge (Borkman 1976: 450-51).

Hine has suggested that, in the Mumsnet discussions she analysed, 'personal experience was evaluated on a par with, and often favoured over, formal scientific knowledge' (Hine 2012:15). Mumsnet is a female dominated community, and a feminist critique of medicine holds that 'women's own experience is devalued by comparison with that of doctors' expert 'knowledge' (Doyal 1994:145). Significantly, Madge and O'Connor have argued that the virtual space of online communities allows women to 'bypass dominant health discourses and power relations' (Madge & O'Connor 2006:210). In addition, the advice offered on Mumsnet is frequently very specific, actionable advice. Pedersen and Smithson (2013) link this 'straight-talking' style to the middle-class demographic on the site and suggest that this is more important to Mumsnet users than the sort of 'mere sympathy' offered by other parenting networks.

In research by Nettleton and colleagues, respondents stated that they would not seek or trust information from chat rooms as 'it's only an opinion' (Nettleton et al 2005: 983). However, as the authors point out, this 'does not reveal any underlying truth' but is an example of how people construct themselves as 'careful, discriminating' and 'sensible rather than opinionated and misguided' (Nettleton et al 2005:983). On Mumsnet, parents do occasionally acknowledge the fact that they are seeking advice from potentially unreliable sources, for example the mother of the constipated toddler explained her decision to seek help from 'complete strangers' on the forum as being due to 'sleep deprivation', which suggests that it is somehow out of character. However, the fact that other users are 'strangers' maybe a considerable attraction, as it allows parents to ask questions and seek help without fear of being judged or typecast (O'Connor and Madge 2004). Research into the use of parenting information accessed via online communities has highlighted that parents seek advice from a range of sources, both on and offline, and make decisions based on an evaluation of information from all sources (O'Connor & Madge 2004). The diversity of responses allows parents to exercise choice over what advice to follow, and although discussions can take place in real-time, they are often asynchronous, allowing parents time to weigh up advice and discuss it rather than being told what to do in a hurried appointment. Poor advice can be challenged by others, offering further protection and potentially enhancing the degree to which people may feel they can trust what they are told.

CONCLUSION

Parents can easily seek the advice of healthcare professionals from a wide range of reliable sources including NHS 111 (previously NHS Direct) or NHS 24, and so it seems evident that they are looking for something else when they choose to seek advice online. I suggest here that it is the experiential knowledge and the support offered by their peers that they look for

and value. It has been proposed that this attribution of worth to experiential knowledge may be in part a reaction to the specialisation and expropriation of knowledge in modern scientific systems (Williams & Calnan 1996: 1616). It may be that online forums offer a way for people to reassert control over knowledge and over how it is used in everyday life. In addition, advice may be more acceptable to people when it is 'personalized to the individual' and 'appears to come from and be directed to similar individuals (i.e. those with a shared social identity)' (Sillence et al 2006: 699). On Mumsnet, there is a high degree of personalisation of advice and there is a strong sense of a shared social identity primarily through the common experience of parenthood, but also perhaps due to the relative homogeneity of the membership as discussed above. Previous research using Mumsnet has noted that the website was a 'friendly non-judgemental space' (Skea et al 2008:1388), though this view has been to some extent challenged by others (Pedersen & Smithson 2013). Nevertheless, personal relationships can develop online 'that are absolutely *real* and meaningful even in the absence of physical, *touchable* matter' (Pacagnella 1997: Page N/A, original emphasis). There is no suggestion that these online relationships are a replacement for face-to-face support networks (O'Connor & Madge 2004), however it is clear that significant online support *is* being sought by, and offered to, parents when making decisions about their children's health and that these networks are a source of valued experiential knowledge. Online networks can operate in a similar manner to offline lay referral networks in both urging and sanctioning help-seeking behaviour when parents are making decisions about their children's health.

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Reflections on 'Gender, Health and Ageing' – Continuity and change after 2 decades

After almost two decades, many issues raised in this article on 'Gender, Health and Ageing' still resonate today, but others seem outdated. The following is still largely applicable:

'It is ironic that such a small amount of research by medical sociologists is devoted to older people despite the high proportion of health resources spent on people above retirement age. What research there is tends to focus on sick older people who are already within the health care system. ... The challenge is to build on the theoretical insights and methodological imperatives from feminist sociology and work on women's health and apply them to older people.' (Arber, 1994: 18)

But other issues raised by the article no longer apply. Although, the importance of hearing the voices of older people and letting older people define issues of relevance to them is widely acknowledged, this is not always the reality in much research. Older people are no longer *primarily* seen as a 'burden', but the mandate is increasingly for older people to be active and engaged in 'productive ageing' or 'successful ageing'. However, this contemporary mandate for older people to be involved in paid work, voluntary work and unpaid care-giving for grandchildren, partners and others, may eclipse social divisions among older people, including their health and physiological capacity to engage in 'productive/successful ageing'. The great research taboo in terms of hearing the voices of older people increasingly involves those in the Fourth Age.

Gender has infused and become firmly embedded within both the Sociology of Health and the Sociology of Ageing, although these two fields remain two separate disciplines, with the former much stronger than the latter (at least in Britain). There are still many research lacunae. For example, we know much less about older men and their health than about older women, and the tendency to treat older women (or older men) as a homogeneous group within research remains widespread. More nuanced research is needed which addresses class, ethnicity, partnership status and sexuality among older people, as well as gender, and fully examines the intersectionality that characterises and differentiates the everyday lives, health and health behaviours of older women and men.

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GENDER, HEALTH AND AGEING

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I am very pleased to be at York giving this plenary to the Medical Sociology Conference. I remember attending my first Medical Sociology Conference, 22 years ago, in York at the Viking Hotel, as a Student on the M.Sc. in Sociology as Applied to Medicine at Bedford College. I can honestly say that I remember nothing about the plenaries, but have vivid and fond memories of walking around the city walls and the disco!

We are all ageing. We all have a personal biography, and we are all influenced by the societal, cultural, economic and political context existing at different times throughout our life course. We are also profoundly influenced by our gender, and how our gender has varying effects at different stages of the life course.

Ageing has at least three meanings:

1. Ageing may refer to the passage of time. I would like to emphasise the importance of taking a *life course approach and life transitions*.

We can only understand people's current health, and ideas about health and illness, through understanding their situational context and their personal biography. So, ageing is about transitions and change.

2. Ageing also refers to *structural age relations*.

Chronological age is often simply 'controlled for' in social research, considered as a 'nuisance' variable which has to be controlled out of our analyses. Instead, we need to see age as associated with social behaviour and social structure.

It is commonplace to observe that our society is age-stratified. The varying norms and expectations of behaviour according to age are socially constructed. Some are enshrined in legal age barriers or 'privileges' for example, to retirement at a certain age, obtaining reduced fare public transport and other concessionary tickets, being allowed to drive a car, or forbidden from driving unless a medical doctor certifies fitness to drive. We need to understand how structured age relations relate to health and other inequalities within our society.

3. Ageing in sociological discourse is primarily identified with later *life, old age or the elderly*, or whatever euphemisms are currently in vogue.

In this paper I will focus mainly on the latter meaning of ageing, but will argue that we can only fully understand later life through using a life course approach, which is situated within the societal context of structured age relations.

Structured age relations and ageism

Ageism refers to structured disadvantages associated with chronological age, and/or negative attitudes associated with advancing age. Gendered ageism refers to the way in which ageism has a differential effect for women and men. For example, mid-life women suffer greater barriers to employment and promotion than men of the same age (Itzin and Phillipson, 1993; Bemard and Phillipson, forthcoming), and in popular discourse women are seen as 'over the hill at 40' (Itzin, 1990).

Societal attitudes towards older people have varied historically and between societies. Since the nineteenth century and increasingly during the twentieth century, older people have been seen as economically redundant, because of non-participation in paid work (Phillipson, 1982; Walker, 1980). In the late twentieth century older people are also portrayed as socially redundant and a burden on society, both financially through the growing cost of state pensions and health care, and a burden on their families, who are expected to provide informal care for them. The prevalence of these societal attitudes has developed into an alarmist 'moral panic' about the perceived growing numbers of older people in the population. This alarmism has been expressed in terms of 'intergenerational conflict' in the aptly titled *Workers versus Pensioners* (Johnson et al, 1989), where elderly people, especially in the USA, are blamed for the poverty of the young. Minkler and Robertson (1991) provide a cogent critique of such positions. Concern in the media and academia with 'demographic facts' about the size of the elderly population, especially the proportionate increase in the number of people aged over 65 or aged over 85, reflects contemporary ageism and reinforces stereotypes of older people as a burden and as a separate group from the rest of society.

The use of exclusionary terms like 'the elderly' draws an implicit contrast between 'us', the non-elderly, the normal, and 'them', the elderly the 'other'. Such terms reinforce perceptions of older people as a distinctive group, which Bytheway (forthcoming) argues characterise older people as a 'burden en bloc'. Yet, the period from 65 onwards spans thirty years and incorporates great diversity and differentiation.

The extent to which older people are seen in this negative light is not only ageist but sexist, since later life is dominated by women. Women outlive men by on average nearly six years (Table 1). This mortality advantage of women means there are fifty percent more women aged 65 and over than men, and among those aged 85 and over, women outnumber men by over 3 to 1. Thus, ageist concerns about the burdens of the very elderly primarily pathologise older women, who form the majority of the very frail and especially those in need of care by the state or from informal carers (Arber and Ginn, 1991a).

Half of women over the age of 65 are widowed (Table 1), yet there is very little sociological interest in widowhood. We know far more about unemployed people and lone parents, which are numerically smaller groups, than about people who are widowed. Widows are invisible both in society and in sociology. Widowhood is primarily an experience of women, there are over four times more elderly widows than widowers.

The Interconnections of Gender, Health and Ageing

Figure 1 illustrates the linkages between gender, health and ageing within sociology. The bold lines indicate strong linkages, and the broken lines suggest weak linkages. Each linkage, and in some cases the resulting sub-discipline, will be discussed; some very briefly, since the material is familiar, and others at greater length.

(i) Sociology of Health and Illness

Sociology of Health and Illness has flourished since the early 1950s, and for a number of years has been the largest sub-group within the British Sociological Association. There is a strong interlinkage between the specialism of sociology of health and broader sociological concerns. Empirical and theoretical work in sociology of health has influenced broader sociological debates, and theoretical work from elsewhere in sociology is readily applied to the field of sociology of health and illness.

(ii) Sociology of Gender

Sociology has been transformed since the early 1970s by the work of feminist sociologists, and gender now forms an integral part of mainstream sociology. In early writing a key distinction was made between sex, primarily used as a variable in analysis and reflecting physiological differences, and gender, referring to the socially constructed nature of gender roles and gender relations as a key structuring force. I later draw contrasts between this distinction and the lack of differentiation in the meaning of the term age.

The methodological stance was crucial, especially in the early days. The dominant approach was qualitative methodology, to hear previously unheard voices and to make visible what was previously invisible. The overriding concern was to take the perspective of the woman within the context of women's own everyday lives. The 'personal is political' became a clarion call, associated with the recognition of how the researcher's own biography influenced the issues to be researched and the interpretation of research data. An associated theme within feminist methodology has been to break down the barriers between the researcher and the researched, to reduce the power imbalance, and where possible empower women through research. These methodological imperatives will be contrasted later with research on later life.

(iii) Gender and Sociology of Health

Research by feminist sociologists has redefined the agenda within the sociology of health. The study of gender roles and relationships is now embedded within the sociology of health, producing pathbreaking research in diverse areas, such as reproductive health, women's unpaid health and caring work, and the historical development of medical knowledge and the professions. The work of many medical sociologists has had a major impact on mainstream sociology, especially the work of Meg Stacey, Hilary Graham and Ann Oakley, to name but a few.

Thus, the triangle in Figure 1, which links sociology, health and gender is drawn with solid lines, demonstrating the integrated nature of work which embraces these three areas. But, the concerns within this triangle have been those of younger women with little application of their pathbreaking insights to the concerns of older women, to which I now begin to turn.

(iv) Sociology of Ageing

The Sociology of Ageing has yet to become a recognised sub-field within British sociology; there is no BSA study group on ageing, and very few (if any) specific courses in sociology of ageing taught within undergraduate sociology degrees. This contrasts with the USA where sociology of ageing has been buoyant for many years, and there is a Research Committee on Sociology of Ageing in the International Sociological Association.

In Britain, there is important research in this area (for example, Jefferys, 1989 and Bytheway et al, 1989), but the professional orientation has been towards the British Society of Gerontology rather than the BSA, and articles published in the journal *Ageing and Society*, rather than mainstream sociological journals. Another legacy has been within social policy,

with work in this area tending to emphasise the social problems of older people (for example, the work of Peter Townsend and Jeremy Tunstall).

It is impossible to do justice to the range of work in the sociology of ageing in this short paper, but my argument is that this work is largely ignored within British sociology. There is a need for a closer linkage which integrates the insights from the sociology of ageing within mainstream sociology, and the sociology of ageing needs to shift from a primarily social problem focus to one which focuses on older people as subjects rather than objects of research, and examines a wide range of sociological research issues focusing on older people (Arber and Ginn, 1991b).

The nascent state of the sociology of ageing can be seen from the lack of refinement of the term 'age'. A parallel distinction to that which contrasts sex and gender needs to be made for the term 'age'. Most writing makes no clear distinction between the following three meanings of age:

Chronological age, which refers to the individual's age in years. This is the variable most often used in research studies and is enshrined in legal restrictions and privileges. In research it is usually assumed to be closely identified with the other two meanings of age.

Physiological age refers to the ageing process as defined by the medical profession. Physiological age is a medically constructed concept associated with the ageing body. Physiological changes occur with ageing in terms of the composition of the bones, the process of degeneration of body tissue and functional impairment, but these changes cannot simply be read off from chronological age. We know that the level of functional impairment of people aged 65-69 who were previously in semi-skilled and unskilled jobs is greater than among the higher middle class who are over five years older (Arber and Ginn, 1993). Thus, physiological age is socially structured.

Social age is socially constructed and in some ways is comparable to the concept 'gender'. However, social age has at least three different meanings: (i) it refers to the age norms about appropriate behaviours for someone of a certain chronological (or physiological) age; (ii) it refers to the subjective perception of how old an individual feels, and (iii) it refers to the age the individual is accorded by others.

At present it is problematic to discuss these three different meanings of age and how they interrelate, because of the lack of agreed terminology within sociology to make these conceptual distinctions.

The theoretical insights from excellent recent work in the sociology of disability (e.g. Oliver, 1990; Lonsdale, 1989; Morris, 1992) could profitably be applied to later life. But their focus is almost entirely on disabled people of working age. This again illustrates the privileging of the working ages over the retirement ages, since the vast majority of all disabled people are over age 65 (Martin et al, 1988).

(v) **Sociology of Gender and Ageing**

It is surprising given the richness of work by feminist sociologists that there has been so little work on older women (Arber and Ginn, 1991b), although this relative neglect is beginning to be rectified (e.g. Peace, 1986; Arber and Ginn, 1991a, forthcoming; Bernard and Meade, 1993).

The impact of feminist sociologists has not only been negligible, but has contributed to the pathologisation of older women. Countless studies of caring have examined the 'burdens' faced by younger and mid-life women in providing informal care to their ageing parents, focusing on how this has constrained women's opportunities for paid employment and other

activities (cf. Nissel and Bonnerjea, 1982; Lewis and Meredith, 1988; Brody, 1981). Since the majority of older people in need of care are women, these studies have in effect objectified older women as the 'problem' the 'burden' to be cared for, the 'other'.

Within official discourse on caring all elderly people are seen as potentially in need of care. For example, the OPCS Informal Carers survey (Green, 1988) identified carers as anyone who 'looks after (or helps) someone who is sick, handicapped or elderly'. This identity of age with needing care fuels ageist images of elderly people as a burden. It also makes invisible all Services, care, and unpaid work performed by older people for each other and to the younger generation. Older people's role in voluntary activities, political organisations and community activities is ignored. The following personal experience illustrates that the balance of support may be in the opposite direction from our conventional assumptions:

My 79 year old father-in-law provides all the required care for my 85 year old housebound mother-in-law, but he would be unlikely to define himself as a carer. He also does all our gardening, including growing vegetables, helps with decorating and does all our evening

'babysitting' for three children. My neighbour has an 80 year old mother who looks after her three children whenever required, including picking them up from school.

Older people's contribution through unpaid work to their own generation and to the younger generation is as invisible today as was the case twenty years ago for women's unpaid domestic and caring work.

(vi) Ageing and Health within Sociology

It is ironic that such a small amount of research by medical sociologists is devoted to older people despite the high proportion of health resources spent on people above retirement age. What research there is tends to focus on sick older people who are already within the health care system. There is very little research on the majority of older people, who have good health and no functional impairment. For example, medical sociologists have learnt a great deal over the last two decades about lay ideas of health and about illness behaviour, but these studies have all excluded those over the age of 65, as if their illness behaviour and ideas about health are uninteresting and unimportant.

The exclusion of elderly people from 'normal' medical sociological research, as opposed to focusing on the health care problems and needs of elderly people, is exemplified in the design of many studies, for example, the Glasgow cohort studies. These began in 1987 and aim to follow up three age cohorts, aged 15, 35 and 55, for twenty years. The lack of a 70 or 75 year old cohort suggests the implicit assumption that there are no (or few) social factors influencing health among older age groups, or that they are uninteresting. This is a false assumption, since inequalities in health are almost as great among those over age 65 as at younger ages (Arber and Ginn, 1993).

(vii) Gender, Health and Ageing within Sociology

Sociological work on gender and health in later life is almost uncharted territory, except for some notable exceptions, which should inspire others. The work of Helen Evers has been particularly significant (for example, Evers, 1981, 1985), and more recently Hockey and James (1993).

The challenge is to build on the theoretical insights and methodological imperatives from feminist sociology and work on women's health and apply them to older people. There is a need to take on the perspectives of older women and men, to give them a voice, and provide the opportunity for older people to define the issues of relevance to them. We need to move the personal concerns and priorities of older people to the centre-stage of research in

sociology of health and illness, seeing older people as the subjects rather than the objects of research.

The potential research agenda is long, and I can only give a partial list here, which should be seen as indicative of the potential for theoretical insight and understanding which would come from such research. Potential research areas include:

- the meaning of dependency, independence and autonomy to older people, and the strategies used to minimise dependence on others.
- the applicability of insights from sociological literature on disability and disabled women.
- the sociology of the ageing body, the meaning of ageing bodies to women and men. The key role of health and the functioning of the body within the everyday lives of older people.
- the contribution of older women and men to their own health, the health and well-being of their peers and the younger generation.
- relations of power in interactions between older people and health care providers, the implications of age relations, and how these are cross-cut by the gender of the patient and the provider.
- age-relations at the macro-level, in terms of the position of older women and men in society and within the health care system.

Sociological research on the health of older women and men not only needs to build on the theoretical and methodological insights from feminist sociology, but needs to utilise a life course perspective, and be sensitive to structural inequalities among older people, in particular how material and social resources in later life are shaped by gender, class, and ethnicity.

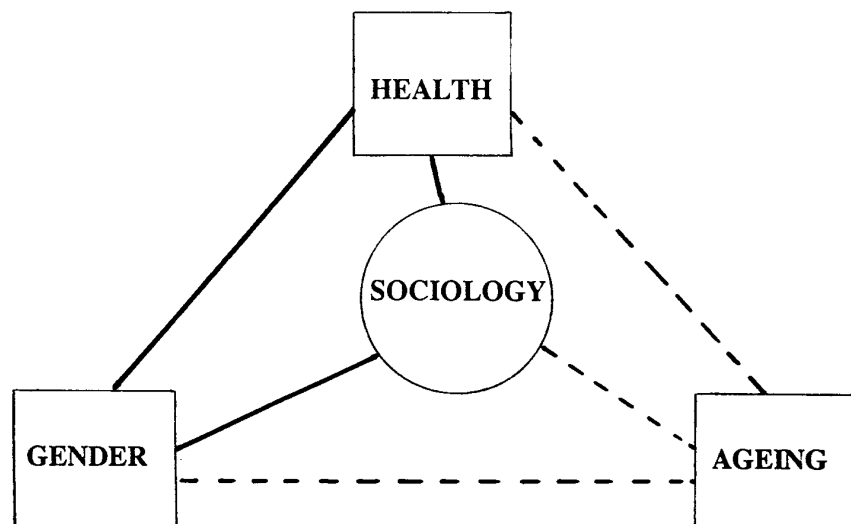
Table 1.

Demographic Characteristics of Women and Men Aged 65 and over, England and Wales.

	<u>Women</u>	<u>Men</u>	<u>Sex Ratio</u> (Women/Men)
<u>(a) By Age Group %</u> (1992)			
65-74	51.0	62.4	1.21
75-84	35.8	31.3	1.70
85+	13.2	6.3	3.12
	100%	100%	
All 65+ (thousands)	(4,879)	(3,283)	1.49
% 65+ in population	18.6%	13.1%	
<u>(b) Marital Status %</u> (1990)			
Married	38.3	72.4	0.79
Widowed	49.3	17.1	4.30
Divorced	3.4	3.1	1.65
Never Married	9.1	7.5	1.81
	100%	100%	
<u>(c) Expectation of Life at Birth, Years</u>			<u>Sex Differentia</u>
1971	75.2	69.0	6.2 yrs
1990	78.7	73.2	5.5 yrs

Source: OPCS. Population Trends 1993, 74. London: HMSO, Tables 6,7 and 17.**Figure 1**

Gender, Health And Ageing



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Reports from the BSA Medical Sociology Group 45th Annual Conference

MEDSOC: IMPRESSIONS OF A FIRST TIMER

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Well, where to begin? I wanted to write a few words to create a personal record of my experience at the conference. When reflecting on what to write, I started by attempting to summarise the sessions I had attended and had found most inspiring. As I looked at the 40 pages of notes I had made during the conference, I realized that I needed to change tack, and decided instead to document a few things that made MedSoc different. In the spirit of MedSoc, I thought I'd share them.

Although a MedSoc novice, I have attended a large number of conferences throughout my working life. One of the first things that struck me when arriving, was the family like feel (and I'm not just referring to the Scamblers!) Everyone was so friendly. There wasn't a meal that I sat down to, where someone didn't introduce themselves and strike up a conversation.

I had arrived feeling a little star struck as I paged through lists of names of people whose work I had read and admired in the delegate log. The opportunity to hear them speak has been inspirational. The mix of experience and youth (in terms of experience not age) of the authors who presented papers was fantastic. Not only something for everyone in terms of content, but also in relation to opportunity to present and get feed back.

Catherine Pope, in her plenary speech introduction, talked about her feelings as she had sat in the audience in years past, unable to imagine she would ever be someone standing up and talking. My sentiments exactly!

The quality (and quantity) of papers was perhaps a little overwhelming and despite any insinuation from fellow conference dinner goers that it was the wine, I felt exhausted by Friday.

At the risk of sounding like a gushing schoolgirl, I also wanted to mention the general friendly, approachable atmosphere where sharing of ideas is supported and advice both freely given and well received. As someone whose worst nightmare is standing up and speaking in public, MedSoc would certainly be my choice of place to bare my study's soul.

So, rejuvenated and reinvigorated, I wanted to say thank you and looking forward to next year!

**PUBLIC HEALTH AND THE ENVIRONMENT: SOCIOLOGICAL PERSPECTIVES
A SYMPOSIUM ON THURSDAY 12TH OF SEPTEMBER 2013****Oli Williams**

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I recently received a funded place at the MedSoc annual conference and it was suggested to me that as such I may want to write a short commentary about the conference. As I am very grateful of the support I received and really enjoyed my time at the conference I felt this was the least I could do to in some way express my gratitude. I have chosen to write a report about the symposium entitled 'Public Health and the Environment: Sociological Perspectives' that took place on the second day of the conference.

With a conference programme so rich in interest, attending one of the symposia at the recent BSA MedSoc annual conference at the University of York almost seemed like a decadent way to spend an hour and forty minutes. Dedicating that amount of time to one session meant necessarily missing some of the many interesting papers I'd pencilled a star next to when before the event I was planning what to attend based entirely on intrigue with no regard for logistics. Not only that but being able to sit in one place for such a length of time and avoid multiple mad dashes to far flung rooms seemed a convenient luxury that I couldn't be sure wasn't swaying my decision. Whether it was a decadent decision or not, choosing to attend the '*Public Health and the Environment*' symposium, chaired by Dr Daniel Wight, proved to be a sound one.

As a first time attendee of a MedSoc conference and a fortunate, as well as very grateful, recipient of one of the funded places offered to postgraduate students, I was keen to make the most of the three days. I attended as many sessions as I could and frequently found myself interested and engaged by those presenting. Limiting myself to only reviewing one of these sessions though has seen the only symposium I managed to attend come to the forefront of my mind. The stated aim of the session was to bring sociological perspectives to bear upon the interaction between health and the global environment and interrogate how public health might engage with eminent ecological issues. All three presentations delivered on this front but it was Professor Nick Fox's, in between Richard Compton's and Maya Gislason's, that proved to stimulate most of the debate in the following discussion.

Professor Fox's argument for the adoption of an anti-humanist approach to issues of the environment and health proved to be divisive. In fact, it would not be amiss to write that it could be considered to have been a largely unpopular proposition in the room. Even as he was speaking I sensed that his arguments may well be received about as enthusiastically as Chris Packham's were by Frank Skinner, the host of Room 101, when he was asked which animal he would rid the planet of and he chose humans (as you're reading this I guess you don't need me to tell you that Skinner rejected Packham's suggestion to banish us to the bin of nightmares). This reaction is perhaps unsurprising as you could argue that anthropocentrism is an expected bias within the social sciences. But it was this prejudice that made the argument for anti-humanism seem even more radical than it might have been in another room and stimulated a stirring discussion. As an embittered Englishman who romanticises martyrdom, I was increasingly convinced of the necessity of my, or indeed our,

subordination the longer Professor Fox's talk went on but I seemed to be on the less populated pole of persuasion. The general negative reaction in the room may be considered to be representative of the reaction that would be garnered more generally and presented an unfortunate truth. The merit of an argument can be overshadowed by its popularity or lack thereof and this is especially so when its intention is to influence the policy of a democratically elected government. I was convinced but such an approach to the environment and health can't really be done on a small scale.

This was the joy and agony of attending this symposium and being exposed to and engaged by Professor Fox's arguments. His is an argument I feel needs to be heard and accepted by people in power if we are, as a global community, serious about addressing the pressing ecological issues. It seems though that it is also likely to be an unpopular argument. Adopting an anti-humanist approach may be what is most beneficial for the environment, and possibly even most beneficial for human health at large, but it is unlikely to be popular with those privileged enough to take environmentally damaging and unsustainable lifestyles for granted. Unfortunately, I couldn't see past what I perceive as a reality; no matter how theoretically sound an anti-humanist approach to environmental and health issues is, the privileged minority have influence and are more likely to vote to maintain their unsustainable privilege than adopt an approach that subverts human 'needs'. So, although I had been thoroughly engaged, it was with regret that I left the symposium as I reflected that the adoption of Professor Fox's approach seemed to necessitate Chris Packham having been successful in having the trap door opened to his selection. I know what you're thinking, why did we give so much responsibility to Frank Skinner? It would seem we were doomed either way.

SYMPOSIUM ON PUBLIC HEALTH AND THE ENVIRONMENT: SOCIOLOGICAL PERSPECTIVES**Rachel Hale**

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The format of this symposium consisted of three 20-minute papers, followed by half an hour of open discussion of the topics raised. The papers were presented by Nick Fox (Durham University), Richard Compton (King's College London) and Maya Gislason (University of Sussex). Each of the presenters called for medical sociology's attention to be turned to environmental issues and they all emphasised the anthropocentric nature of healthcare and research. The symposium was chaired by Daniel Wright, of the MRC Social and Public Health Sciences Unit.

Richard Compton considered the relationship between medical sociology and climate change. Richard highlighted the anthropocentric nature of the main discipline of sociology, and of medical sociology. Richard proposed that despite the considerable attention that has been given by health researchers to the health implications of climate change, medical sociology has failed to critically assess these developments or make theoretical and empirical contributions. Richard suggested a range of issues that medical sociology addresses, including the impact of climate change on health, and the aims and organization of health care/services and its impact on the environment. Nick concluded by proposing that in future environmental issues be included as a MedSoc conference stream, rather than just a special symposia.

Nick Fox outlined five perspectives on 'health and the environment'. The first was that human health is threatened by environmental factors (for example, by climate change). The second, that improving the environment can enhance human health. The third, that improvements in health threaten the environment (for example, through population growth and economic development). The fourth, that initiatives can reduce the environmental impact of health care. And the fifth concerned Gaia-inspired conceptions of humans as part of a self-regulating environmental system.

Nick asked whether human health and environmental health are potentially antagonistic, contradictory forces, how human and environmental health can be complementary, and should human and environmental health have priority?

Nick asserted that most healthcare and medical therapy is inevitably anthropocentric, and that health has become a 'good' that is almost unquestionable. An anti-humanist, neo-materialist approach was proposed as an alternative to an anthropocentric approach to health. An anti-humanist approach would focus on the non-human, the inanimate and social formations, and would consider the way these elements affect each other; where humans would no longer be the sole agents. Nick suggested taking a Deleuzian approach which reveals that the environment is no longer separate from bodies. The latter are part of an assemblage that is 'environment' and health is a consequence of the capacity that bodies have, and is a by-product of sustainability or resilience.

Maya Gislason considered 'Health in the Anthropocene'. Maya considered the difference between 'tame' problems, which she says science was developed to deal with, and 'wicked' and 'super wicked' problems or social messes of 'Ecological Health Research and Practice'.

Maya drew attention to the interplay between social and ecological factors in many contemporary disease burdens and drew attention to the newly emerging field of 'ecological health', which she said is grounded in the use of ecosystem approaches to health research and practice.

The symposium was well attended and the open discussion was diverse. Among the topics discussed was the relationship between humans' exploitation and consumption of non-human animals, particularly as food sources, and the affect of this on the environment and human health. Some audience members suggested veganism as a solution to some of these issues. I was particularly interested in this part of the discussion, both as a vegetarian and, as a researcher interested in the zoonotic disease influenza.

SYMPOSIUM ON PUBLIC HEALTH AND THE ENVIRONMENT: SOCIOLOGICAL PERSPECTIVES**Naomi Wood**

PhD Student, Institute of Population Health, University of Manchester, UK

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This was the first year that I have attended the Medical Sociology Group Annual Conference. With such a huge and varied programme of events, I wanted to take the opportunity to attend talks outside of my 'usual' home of study (a Primary Care Research Centre). With this intention, I attended the symposium on Public Health and the Environment: Sociological Perspectives (Fox, Wight, Compton & Gislason).

The speakers at this symposium presented and discussed (in various ways) the idea that studies of health and illness are 'anthropocentric': that human bodies and human experiences are privileged. In the context of medical sociology and medical anthropology this might seem to be an unproblematic statement; both disciplines consider human experience (of health and illness) within particular social, cultural and structural contexts. However, the speakers in this symposium presented a challenge to think about the relationship between people and their environment in a different way; not just to consider context as shaping experiences of health and illness but to consider how humans (and human health and illness) affect the environment (as a context upon which human life depends).

In terms of our (human) relationship with the environment, Maya Gislason talked about an 'invisibility' of the environment; that unless an environmental emergency occurs, for example a flood or an earthquake, the environment remains invisible. I understood this as a sort of 'taken-for-granted-ness' in the way that we live within our physical environment; that when it 'works' and provides what we need (food, water, shelter, etc.) we don't notice it or experience it as something that requires attention. An environmental emergency challenges this invisibility and prompts a change in the awareness that humans have of their environment.

It struck me that this line of thought presented an interesting parallel with ideas about changes in awareness of the body in different states of health and illness; that it is only when the body is in crisis, or is not functioning in the expected way, that it becomes visible to the person. In his book *The Absent Body*, Drew Leder (1990) gives the example of pain as a stimulus for a change in the perception of the body, which results in a call for action:

'My own body becomes the object not just of perception and interpretation but of action. I seek medication, physical therapies, whatever will help. My projects are reorganized around the attempt to cope with or remove the pain. Instead of just acting from the body, I act toward it.' (p78-79)

Like the idea of an environmental crisis changing our awareness of our physical surroundings, the experience of pain also demands a different kind of attention, and a stimulus to act. The idea of 'de-humanising' research on health and illness as an alternative to anthropocentric research agendas can be seen not as a question of removing human bodies and experience but demanding a different kind of attention to it. To apply Leder's words, 'dehumanising' studies of health and illness is a call for acting *toward* the environment instead of *from* it.

My hope in attending this conference was that I would not only hear something about what I already know but be challenged to apply that to other questions of health and illness. Listening to the speakers at this symposium did exactly that – and it served as a great reminder to keep an open mind along the way in my PhD.

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OFFLINE HEALTH**Lucy Perry**

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I was lucky enough to be given a funded student place at this year's BSA MedSoc conference in York, and was asked to write a short commentary about my experience. I had intended to write about my overall impressions of the event but one of the final presentations particularly caught my attention in quite an unsettling yet thought-provoking way, and so I decided to comment on this instead. The paper was given by Aksel Tjora from the Norwegian University of Science and Technology and had the intriguing title of 'Offline Health'. In relation to the dramatic increase in smartphone use and internet-based social media in recent years, the study looks at the effects of this new information-heavy lifestyle on health. This is achieved not by exploring the health and behaviours of people who are regularly online, but by observing the effects of being, and staying, offline. In a nutshell, 13 participants who were daily internet users were asked to go 'offline' for 3 weeks, and were interviewed regularly throughout this time. As someone who is very much a daily internet user, and possibly (or at least on the borderline of being) what Tjora called a 'digital native', I could sympathise with these participants.

Tjora explained that, from the outset, he was unsure how, if at all, being 'offline' would affect the health of his participants. Although the project was in the early stages, and a full analysis had not yet been undertaken, some of the participant quotes were shared with the audience. Terms that you would more likely find in narratives about stress, pain and addiction were abundant in the quotes from the interviews conducted only a few days in to the 3 week abstinence. Clearly, and quite remarkably so, this is something which does have an effect on people's health, and not solely on their social relationships and sense of community.

At this stage, I was beginning to hope that the findings ended there, and that the obvious conclusion to be drawn was that going offline must be bad for your health. Inevitably however, the quotes from the interviews conducted later in the 3 week 'offline' period were far more positive with participants reporting that they felt less stressed, were able to do more, were able to concentrate for longer, and (as I was fearing) study harder. It appeared that people felt refreshed and even calmer after only a short amount of time not using the internet.

In this excellent presentation, Aksel Tjora raised some key issues and concerns about this relatively new phenomenon and lifestyle where the internet and social media not only facilitate our rapid access of information and multiple forms of communication, but also hinders our ability to concentrate and work productively. Ultimately, this may affect our health. I found myself feeling slightly uneasy during the presentation because of the creeping realisation that, while I found the quotes amusing (things such as 'this is hell'), I could also identify with some of the feelings the participants were describing.

MedSoc 2013 Poster Presentations

As is the case at many Conferences, there was a display of Posters at MedSoc 2013, held at The University of York from 11th – 13th September. The Conference reportedly had the best ever attendance figures and likewise there were a total of 50 Poster submissions. Delegates were asked to vote for the best and the winners, announced at the Conference Dinner, were Wood, Sanders, & Vassilev with their poster entitled “*The Impact of Migration on Managing a Long-term Condition: a Qualitative Review and Synthesis of Existing Research*”

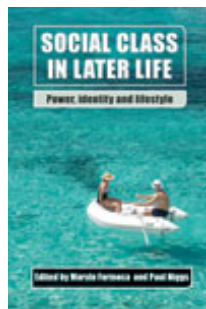
In what may be a ‘first’ for a journal such as Medical Sociology online (MSo), we are delighted to be able to publish more than half of the posters exhibited at MedSoc 2013 on our website, including, we are delighted to say, the winning entry. They can be seen by visiting our website www.medsoconline.org (or you can go directly to the page: <http://goo.gl/pNzavM>).

We hope that MSO will be able to publish posters from future Conferences online and we would welcome approaches from organisers as well as feedback from our readers on this new feature.



Wood, Sanders, & Vassilev: “*The Impact of Migration on Managing a Long-term Condition: a Qualitative Review and Synthesis of Existing Research*”

Book Review



Marvin Formosa, Paul Higgs (Editors)

Social Class in Later Life: Power, Identity and Lifestyle

Policy Press, Bristol, UK, 2013, Hardback

ISBN: 9781447300588

208pp

Reviewer: Pamela Pitman Brown, PhD

Winston-Salem State University, USA

To be able to review a book for a journal so soon after its publication is often a challenging task for the reviewer. The title of the book struck me as compelling since some gerontologists discuss social class as contextual for later life, but do not use social class as analysis the way we may use health or economic inequalities. The text emerged from a symposium titled *Theorising Social Class in Later Life: Power, Identity and Lifestyle*, at the 19th World Congress on Gerontology and Geriatrics (2009) of the *International Association of Gerontology and Geriatrics* (IAGG) in Paris, of which Formosa and Higgs were the conveners. The book is an outgrowth of both the 19th and 20th World Congress (2013 in Seoul) and the *British Sociological Association 2013 Annual Conference*, thus the essays are quite timely and include up-to-date material. The text is available in the UK from Policy Press at the University of Bristol, and within the US is available from Chicago University Press.

As an undergraduate professor, I customarily instruct my students to read the *Preface/Foreword* of a text to garner a more precise understanding of authors/editors standpoint. The *Foreword* by Malcolm Johnson relates the historical perspectives of sociologists toward class divisions and class formations, as well as how the subdisciplines of gerontology and medical sociology lost interest in social class as a variable during the later 20th century. Johnson points out various key players and seminal works within the gerontological discipline, and additionally offers the reader a glimpse into the critical gerontology movement. He also discusses the text's theoretical framework based upon Pierre Bourdieu's 1984 concept of *notions of distinction, reproduction, and habitus*. The conciseness of Johnson's foreword provides student readers the underpinnings of the upcoming chapters, allowing them to read and think critically throughout the remainder of the text.

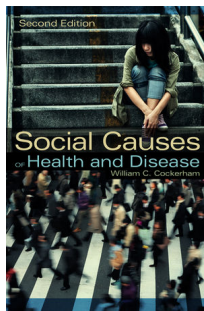
Formosa and Higgs' introduction chapter continues to inform the reader of the historical background of social class and class trajectories within gerontology. There is also to a certain degree a chastisement of social gerontologists for reporting research findings bereft of theoretical frameworks and for operationalising *class* with socio-economic status or job-status scales. Formosa and Higgs do point out there are gerontologists who acknowledge this absence of social class as a variable by quoting Settersten and Trauten (2009). The remainder of the introduction then relays the structure of the remainder of the text and of the intended objectives. Additionally, the reference list at the end of the introduction is one that

highlights influential writings within the discipline of gerontology, allows the wonderful opportunity for students to read alongside the text the articles contained in the reference list.

The following eight chapters view social class and ageing through various lens: affluence and social mobility (Bottero, Chapter 2); marginalization of social class via its intersection with ageing, and the tilt toward a social status (i.e. gender and ethnicity) perspective and globalisation (Phillipson, Chapter 3); social class as both an independent and dependent variable (Lopez, Chapter 4); social class and age identity changes in later life (Hyde & Jones, Chapter 5); pension and old age security within low-, middle-, or high-income countries (Storellie & Williamson, Chapter 6); challenging the notions of health inequality via social class from a divergent/convergent perspective (Jones & Higgs, Chapter 7); the 'who receives, who needs, who gives' care conundrum on the basis of social class and family resources (Victor, Chapter 8); and the unknown effects of socio-economic status on social work services in later life (Hafford-Letchfield, Chapter 9)

In the final chapter, the editors present a reflection on the previous eight chapters and suggest interventions in the incorporation of social class into more gerontological knowledge and research. Higgs and Formosa also revisit *generational habitus*, particularly within the Boomer demographic who value individualisation and choice, questioning how will the Boomers construct or deconstruct retirement, social class, and social policy even across globalised interests. Linking old age euphemistically to a social disease, they point out that old age is "an epiphenomenon of earlier points in the life course" (p. 173), which have over the course of time become more and more tenuous, and even more contingent on the how/why/when/how of retirement, including the second 'how' of retirement financing. Many undergraduate students will enjoy the referencing of a *zombie category* for later life, which unlocks a window to introduce them to Ulrich Beck vis-à-vis Jonathan Rutherford's 1999 interview. These small tidbits are wonderful teaching opportunities, capturing students' attention, expanding their sociological knowledge, and holding their interests for a while! I highly recommend this text at both the undergraduate and graduate level of study within gerontology/sociology and in particular within the realm of aging and inequalities across the lifecourse. This text allowed me to analyse critically what research and theoretical perspectives we are using in our gerontological foundation courses.

Book Review



William C. Cockerham

Social Causes of Health and Disease, 2nd Edition

Polity, Cambridge, UK, 2012, Paperback

ISBN: 9780745661209

256pp

Reviewer: Sasha Scambler

King's College London, UK

The central thesis of this book is that social factors have a 'direct causal effect on physical health and illness'. In this book William Cockerham makes a compelling case that takes us beyond the widely accepted assertion that most diseases have social connections. There is plenty of evidence that the social context can shape an individual or population's risk of exposure to disease, can shape an individual's susceptibility to developing the disease and can affect the course and outcome of diseases. And the evidence shows that this is true regardless of whether the disease is infectious, long-term, degenerative or genetic. In this second edition of the book, Cockerham uses a plethora of updated evidence from the US and UK to make the argument that biological entities (viruses, cancers etc.) work in conjunction with social conditions to create the environment in which disease occurs.

In the first chapter Cockerham draws on case studies of smoking, diabetes and HIV/AIDS to illustrate the direct causal power of social factors. Taking the example of diabetes, he shows that diabetes rates are soaring in the US and that the growth rate is socially patterned with higher rates amongst the poor, blacks and Hispanics. Whilst genetics plays a critical role, the acceleration of new cases cannot be explained by genetics alone. Poverty linked social behaviours (around diet, exercise and access to and use of medical care) have been identified as the culprits. But interestingly race has also emerged as a significant factor with working class white areas experiencing moderate rates of diabetes whilst low income black and Hispanic areas have a 'virtual epidemic'. These patterns are acknowledged but the focus of health research has been firmly entrenched within the biomedical model looking for biological causes of disease and factors which might influence these and leading to an individualised approach which largely ignores structural factors. Cockerham argues that we need to build on Link & Phelan's Fundamental Cause Theory (1995) and the body of work that followed on from it and focus in on the structural factors which shape health and illness. He suggests that this paradigm shift has started in the US and UK but needs to be built on.

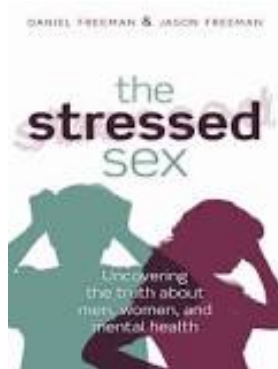
The second and third chapters build on this thesis, setting the scene for an exploration of the empirical evidence in relation to structure. In the second chapter the argument is made that the unique contribution of medical sociology is the use of theory to explain the interplay between individuals and society that emerges through empirical studies. The main theories that have been used within medical sociology are outlined. Cockerham suggests that the tendency to focus on agency and social construction over structural theories has led to a

situation where the effects of social structures on health are largely ignored. He notes, however, that re-emergence of the structure/agency debate is providing opportunities to bring structure back in. An example of this is presented in the next chapter where the Health Lifestyles Model (Cockerham 2005) is presented as a way of challenging the trend towards the individualisation of health lifestyles research. The Health Lifestyles Model is presented as a way of acknowledging and seeking to understand the impact of structural factors on the practices that are usually the focus of lifestyles research (alcohol use, smoking, diet etc.).

Each of the following chapters of the book focuses on a neo-structural component (class, age, gender, race/ethnicity, neighbourhood and social capital) to assess the evidence with regards to the causal qualities of structure in relation to health and disease. The chapters on social class conclude that suggesting the relationship between class and health is just an association overlooks the power of class to sort people in to categories which have better or worse health/longevity. Class clearly meets all of the requirements laid out by Link and Phelan to qualify as a fundamental cause. Empirical evidence is used to demonstrate the role of gender as a fundamental cause through the process of socialisation and the cohort effect demonstrates the equivalent for age. Race/ethnicity, however, are socially constructed categories which do not meet the criteria and it is argued that their effects can be accounted for through class. Both the environmental conditions that individuals live in – external to themselves but largely shaped by social circumstances – and the social capital networks available are presented to demonstrate further the interaction between individual level and structural level factors in creating health and disease and the need for further work, particularly around the concept of social capital.

This book calls for a paradigm shift away from methodological individualism towards a more balanced approach that includes 'a renewed focus on structural effects. The causal power of class in particular is so pervasive that it produces effects in other structural factors (age, gender and race/ethnicity) over and above the effects of these factors themselves. Cockerham makes a compelling argument, drawing on the latest research from the US and the UK to make his case and calling on medical sociologists to utilise their unique theoretical expertise to challenge the methodological individualism that is pervasive in the field of health. Overall this book is highly recommended and a must read for those working and/or studying in the fields of medical sociology and public health.

Book Review



Freeman, D. and Freeman, J.

The Stressed Sex - Uncovering the Truth about Men, Women and Mental Health

Oxford University Press, Oxford, UK, 2013, Hardback

ISBN: 978-0-19-965135-1

267pp

Reviewer: Jacqueline H Watts

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I first came across this book when listening to an edition of the BBC's long-running Radio 4 programme Woman's Hour in which one of the book's authors, Daniel Freeman, set out his conceptual and empirical 'stall' on the matter of whether rates of psychological disorder are different for men and women. Highlighting some contentious issues such as changing disease classifications and contradictory 'expert opinion', his clear exposition of both the book's key findings and limitations was very engaging and I ordered the book immediately. On reading it, I have not been disappointed. The accessible writing style that includes explanation of scientific and technical terms sets out with great clarity what is currently 'known' about gender and mental distress and also what, through rigorous analysis, we might reasonably 'claim' or understand as causality in terms of women's and men's risk of suffering mental health problems.

Mental health issues that most commonly centre on psychological and emotional problems are a global concern and, according to the World Health Organisation, constitute the number one cause of disability in the world. 10-20 per cent of people will experience depression at some point in their lives and women are more likely than men to develop the condition. Data from a broad range of epidemiological surveys consistently attest to psychological differences between the sexes. However, the extent to which these differences are the result of biological factors or the product of social and cultural factors points to the pivotal issue of gender and mental health that the book's authors describe as a battleground with sociologists and epidemiologists as the chief protagonists. The feminist lobby has made a significant contribution to the debate about gender and mental health arguing that psychological disorder is essentially a gender issue with high numbers of women traditionally treated for mental illness by the overwhelmingly male-dominated profession of psychiatry. It is this cultural construction of mental health and specifically the question of whether madness is a female malady that is at the core of the book's polemic.

The book is usefully organised into two distinct parts essentially characterised by the 'what' and the 'why'. The first part presents data from 12 national surveys on the patterns and prevalence of psychiatric problems and the second part discusses how differences between men and women in terms of their experiences of mental health might be explained.

For the first part the authors, having applied a set of strict criteria, present data drawn from 12 selected national large-scale surveys that offer an international 'flavour' of mental health prevalence in the population - 3 UK studies, one each from Germany and the Netherlands, two from the US, two from Australia and one each from New Zealand, Chile and South Africa. All twelve surveys focused on 'recent' problems identified according to disorder classifications as set out in the two principal reference books in the world of mental health - the International Classification of Diseases and Health Related Problems (ICD), published by the World Health Organisation and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, commonly known as the DSM. Problems identified in the surveys were wide ranging including eating and sleep disorders, dissociative disorders, substance-related disorders and mood and anxiety disorders such as depression and phobias. Analysis of the survey data by the authors highlights that certain problems such as depression are more prevalent in women and others such as alcohol and substance misuse are more common in men. The old hypothesis that women worry and men drink, though simplistic, appears to hold a kernel of truth. Overall, however, the 12 national surveys discussed by Freeman and Freeman point towards the conclusion that women are more likely than men to experience a mental health disorder.

The second part of the book that for me was the most enjoyable and arresting, sets out to explore the possible reasons for this conclusion and for many readers, these explanations though complex and multi-dimensional, will come as no surprise. In general, women appear to experience higher levels of mental distress because of the demands of their social role as homemaker, carer and breadwinner. These competing roles can give rise to women feeling that they have 'failed' or not 'matched up' in one or more of these aspects with this experienced as negative self concept or low self esteem making women particularly vulnerable to psychological disorders. Mental health problems are usually neither innate nor inevitable and many difficulties would not occur if it were not for the contribution of social pressures connected to gendered expectations and assumptions. The authors thus argue that gender can no longer be assumed to be a marginal issue in considering the causes and treatment of mental illness.

Because of the broadly 'western' context of the survey data on which the authors draw, it is not possible to get a sense of the wider global picture of gender and mental health from this text and that is one of its limitations. However, the authors are transparent about the book's parameters and their intention to interrogate only data from nationally representative samples of adult populations. Despite its narrow focus, I thoroughly recommend this book, not just as an evidence-based academic text for health and social care practitioners and policy-makers, but more widely, not least because it is a 'good read' as well as certainly extending thinking on this important and controversial topic.